

Name _____ DOB: _____ Age _____

Who is your Family Doctor? _____

Who is your Referring Doctor? _____

My primary problem is (check all that applies):

- Back pain Right leg pain Left leg pain Neck pain Right arm pain Left arm pain

When did your pain start? _____

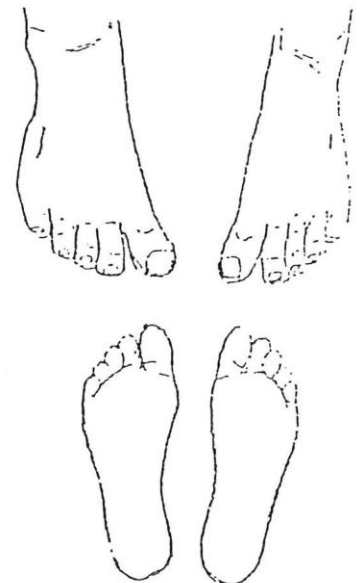
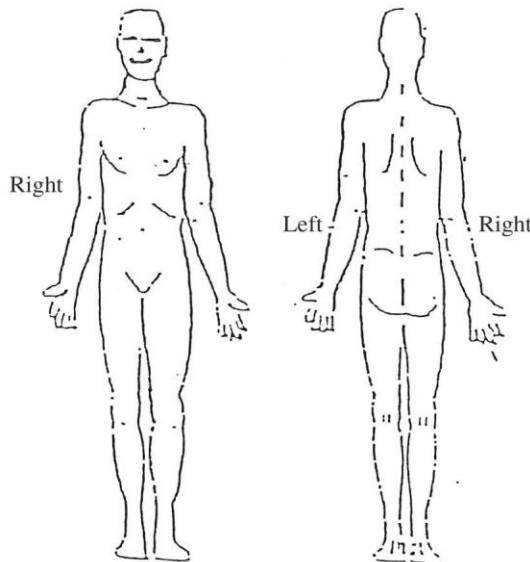
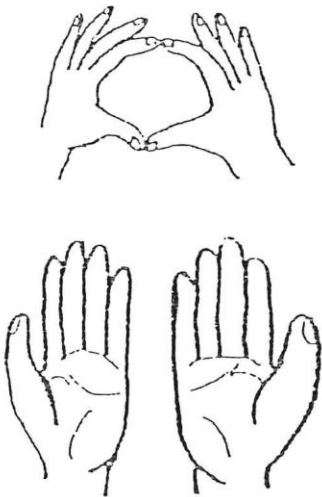
Is your pain a result of an injury, fall, or car accident? Yes (when _____) No

What would you rate your pain on a scale of 1-10: Circle your rating

No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Using the symbols, please mark on the diagram what you are feeling:

<u>Symbol</u>	<u>Sensation</u>
X	Stabbing
+	Pins and needles
O	Numbness
A	Aching
B	Burning



Is your pain getting: Better Same Worse

Have you noticed any numbness/tingling/weakness in your arms or legs?

No Yes, where _____



Patient Name: _____ Date: _____

Have you had new issues controlling your bladder? Yes No

Have you had new issues controlling your bowels? Yes No

If you cough, sneeze, or strain does it cause pain to shoot down your legs? Yes No

Circle all that makes your pain worse:

- Sitting Standing Walking Laying down Bending
- Twisting Morning Evening Activities Driving Other: _____
- Sit to stand Getting out of bed Laying on side Lifting

Circle all that makes your pain better:

- Laying down flat Sitting Walking Standing
- Injections Medications Heat Massage
- Rest Laying on side Ice Therapy
- Other: _____

Do you have pain that wakes you up at night? Yes No

Have you had Physical Therapy within the last year for your spinal condition? Yes No

Have you had any injections for your spinal condition? Yes (when _____) No

Have you ever had surgery on your spine? Yes (when/what area/by whom) No

When _____ What area of the spine _____ by whom _____

Have you had any other treatment for your spine? No Yes (Explain) _____

Have you had any of the following studies?

- Plain x-rays _____ Where _____ When _____
- MRI _____ Where _____ When _____
- Myelograms _____ Where _____ When _____
- CT Scans _____ Where _____ When _____
- EMG/NCS _____ Where _____ When _____
- Dexa or Bone Scans _____ Where _____ When _____
- Discogram _____ Where _____ When _____

Have you ever seen any other Orthopaedic Physician/Chiropractor/Family Physician regarding your Spine?

No Yes Physicians Name: _____ When _____



Patient Name: _____ Date: _____

Do you have or are you being treated for:

- High Blood Pressure Yes No
- Diabetes Yes No
- Heart Problem Yes No
- Lung Problem Yes No
- Liver Problem Yes No
- Kidney Problem Yes No
- Seizures Yes No
- Blood Clots Yes No

Other major health issues: _____

Have you had a heart attack? Yes No

Have you had a stroke? Yes No

Have you had cancer/what kind? No Yes (_____)

Please list any and all procedures/surgeries or major hospitalizations:

1. _____ when _____
2. _____ when _____
3. _____ when _____
4. _____ when _____
5. _____ when _____

Please list all medications (including Natural and vitamins) and reasons for taking them:

	<u>Medications (include strength/number of times per day)</u>	<u>Prescribed by who</u>	<u>Reason taking</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

ALLERGIES:

Please list any DRUG/METAL/LATEX allergy you have OR had and reaction it caused:

	<u>Substance</u>	<u>Reaction</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Patient Name: _____ **Date:** _____

Is there any other information you would like to give us regarding your spine? Yes No

Is there any family history of any spine disorders? No Yes (What _____)

Please list any diseases that run in your family: _____

What (do/did) you do for work? _____

Do you smoke or have you smoked in the last 6 months? Yes (How much _____) No

Do you drink alcohol? Yes (How much _____) No

Have you had any recent fever/chills? Yes No

Have you had any recent chest pain? Yes No

Have you had any recent shortness of breath? Yes No

Have you had any recent weight loss? Yes No

Have you had any recent night sweats? Yes No

How tall are you? _____ **How much do you weigh?** _____

Signature: _____ **Date:** _____